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LEADING ARTICLES

THE PALLIATIVE TREATMENT OF CARCINOMA UTERI.*

E. E. MONTGOMERY, M. D.

PHILADELPHIA,

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A REVIEW of the literature of cancer discloses that the time of the great majority of the students of this subject has been devoted to the development of plans of procedure which will lead to the eradication of the disease and recovery of the victim. I would not wish to be understood as decrying the desirability of all the information which can be secured as to the recognition of its causes and the best means for combating its ravages, but it must be rememberad that under the most favorable circumstances between forty and fifty per cent of the cases which come to our observation have passed the period when radical measures afford a hopeful outlook for a favorable result. Sadder still, it must be said to our shame and sorrow, that but little provision is made for the study and care of this large proportion of sufferers. Unfortunately, the beds allotted to the gyneoclogists are too few and unfavorable for isolation, so that such cases cannot be made comfortable in a hospital because of the danger to others.

Again, cancer cases are necessarily troublesome, require special care and consideration, and finally are sure to terminate fatally, rendering them undesirable to the physicians and to the hospital whose managers are desirous of having a record for its low mortality. The consequence is that with the determination of an unfavorable prognosis the patient finds the doors of the great majority of the hospitals closed against her, and she must be content with such comfort in private as her means will command, and this is generally to become a dope fiend, and after a more or less lengthy period of discomfort fade out of existence.

The palliative treatment is applicable only to those cases, in which the extent of the disease affords no hope from a radical procedure. Indeed, the outlook is so hopeless otherwise that I would advocate resort to a radical procedure in all doubtful cases when the conditions present permit the least possibility for the removal of the diseased tissue.

In many cases operation will fail to prevent a recurrence, but the relief of the abnormal symptoms and the prolongation of life will amply compensate for any discomfort associated with the procedure. Numbers of cases come to mind where patients have enjoyed years of freedom from recurrence atfer operation, when at the time I was doubtful of the benefit to be obtained.

I will take the liberty of recounting one: MRS. H., a patient of Dr. Wm. Flemming, aet 58 years, mother of two children, had been suffering for six months from an offensive bloody discharge. The cervix was pretty well excavated, the margin of the ulcer infiltrated and the uterus fixed. The vagina was scalded and irritated by the discharge. She had been seen by a surgeon who advised against operation. She underwent operation April 10th, 1903, at St. Joseph's Hospital, when through an abdominal incision the ovaries and tubes were found fixed behind the uterus by dense inflammatory adhesions, and were with difficulty set free; each broad ligament was temporarily clamped and cut through, the intervening peritoneum cut across in front of the uterus and the bladder pushed down; the base of the broad ligament was ligated on either side and cut and also the tissue posterior, leaving the vagina unopened. The cervix had been previously fixed through

*Read before the Obstetrical Society of Philadelphia.

the vagina with a double tenaculum. The abdominal wound was packed with gauze, the uterus drawn through the vagina and removed with one-half of the later. The vagina was packed with sterile gauze and the abdominal packing removed. The ovarian arteries were ligated, but there was considerable bleeding low down upon the left side. The left ureter was followed down to its insertion into the bladder, and the internal iliac artery ligated, enlarged lymphatic glands were removed at the bifurcation of the iliac which led to injury of the iliac vein. This opening was closed by a lateral catgut suture. Bleeding in the pelvis was further controlled by quilting the tissues together below the vesical end of the left ureter; iodoform gauze was inserted into the vagina and the peritoneum closed over it, shutting it out of the general peritoneal cavity, after which the abdominal wound was closed. She was discharged May 1, 1903, with the wound entirely healed, and enjoyed good health Dr. Flemming informs me, until two years ago, when she manifested symptoms of cancer of the liver from which she died six months later, having had two years of good health.

The favorable outlook is enhanced by the age of the patient. The earlier in life it manifests itself the worse the prognosis and the more probable the recurrence. When the examination reveals such an extension of the disease to the vaginal walls, the parametrium and the peritoneal surface as to render evident the futility of any effort at extirpation, the operator must content himself with less radical measures.

The ligation of the vessels to starve such a tumor has been suggested, but the ligation of the ovarian and uterine, or even the internal iliac arteries under such circumstances would be a formidable procedure, frequently rendered more difficult by the secondary involvment of the lymph glands. My experience in the ligation of the internal iliacs has not been followed by sufficiently prolonged absence of recurrence to cause me to regard the procedure with favor. The employment of the X-ray or radium have been advocated, but my experience causes me to place but little credence in the value of either.

In deciding what shall be the course of treatment it is well to remember the symptoms; hemorrhage, profuse, offensive discharge, and the cachexia from the absorption of toxic ferments, and direct the measures to the correction of the conditions causing them. Among the earliest plans of treatment for uterine cancer was the employment of caustic agents, and especially strong solutions of zinc chlorid as practiced by Sims. Other agents advocated have been bromin, acid nitrate of mercury, fuming nitric acid, chromic acid, formalin, and the actual and galvanic cautery. As a preliminary to the employment of any of these agents the uterus is carefully curetted. Indeed, occasionally is found a surgeon who contents himself with a mere curetting, but this practice but harrows the field and promotes the more rapid development of the disease. The caustic agents are difficult to manage, while they have a greater destructive influence upon the diseased structures they also corrode the healthy tissues, requiring great care in its protection. The zinc solutions, in spite of every precaution, produce more or less influence upon the vagina and vulva; bromine is objectionable because of its volatility and its irritating effect upon the respiratory tract of the operator; the strong acids are difficult to confine to the diseased portions. Many prefer the Paquelin cautery as being more readily controlled and capable of being applied more directly to the desired point. When there is much excavation of the uterus it becomes very difficult to effectively cauterize the entire surface. My experience leads me to regard formalin as the most serviceable agent.

The procedure consists, first, in careful cleansing of the vagina, the thorough employment of a sharp curette over the ulcerated surface, removing as effectively as possible all of the breaking down tissue. When the walls of the vagina are involved a bougie should be passed into the bladder when curetting the anterior wall, and the finger be introduced into the rectum as a guide for the manipulation over the posterior wall, and care exercised to avoid breaking into the peritoneal cavity. Such an accident should not be considered as a necessary fatal result, for I have several times had the accident occur, and in none of them was it attended with any apparent harmful result. The only disadvantage is that the caustic agent cannot be so effectively applied. Where the cavity cannot be sutured it should be plugged with iodoform gauze, giving the peritoneum an opportunity to become closed with plastic exudate.

When the curetting has been accomplished without preforation, rough edges should be cut away with scissors and the surface irrigated with hot salt solution. Spurting vessels can be temporarily secured with clamp forceps, and later if they continue to bleed, ligated by passing the ligature into the tissue by means of a needle. The oozing from a large surface can generally be controlled by hot irrigation, when it fails the surface can be drawn down and infiltrated with one-fourth dilution of the (1-1000) adrenalin chlorid solution, which constricts the vessels and effec-

tually controls bleeding, then pledgets of cotton squeezed out of a four per cent solution of formalin placed over the affected surface, while the healthy tissues have been previously covered with vaselin. After packing these pledgets over the diseased surfaces they are covered over with iodoform gauze and absorbent cotton to prevent the solution draining over the healthy structures. The removal of the packing in twenty-four hours shows the surface covered with a white dry zone of devitalized tissue, which separates and comes away within the next ten days, or at the farthest, two weeks, leaving a clean raw surface.

Cicatrization may be promoted by packing with iodoform gauze, the employment of drying powders, as boracic acid, aristol, iodoform, or a combination of the latter with tannic acid or powdered charcoal. The surface should occasionally be touched with a solution of silver nitrate or where infiltration and proliferation appears, the formalin solution may be applied.

The saddest cases are those in which the disease rapidly invades the anterior or posterior wall, or both, and permits urine and feces to intermingle with the disintegrating tissues, producing a most horrible stench. The lesion of the bladder affords but little amelioration. The rectal discharge can be sidetracked by the construction of an artificial anus in the groin. This seems to me a desirable course, inasmuch as the procedure can be accomplished under local anesthesia, and the patient can be kept much more clean than by having a leakage of the bowel contents into the vagina. As the disease progresses a stage will be reached when the measures above considered can no longer be effective and the surgeon must be content with allaying discomfort. Cleanliness should be secured by frequent douching with salt solution or combined with formalin (1-1500), solutions of acid carbolic, thymolin, potass. permanganate, zinc chlorid ½ to 1 gr., aq. f℥i and hydrogen peroxid. Probably the most efficient method of deodorizing the parts is to simultaneously introduce into the vagina from separate receptacles a four per cent solution of potass. permanganate and a fifty per cent solution of hydrogen peroxid. The increased oxygenation thus induced cleanses and deodorizes the surface.

The patient should sleep in a well ventilated room. Indeed, it is better that she should sleep in the open. As far as possible she should be kept in ignorance of her true condition. Her mind should be occupied and interested. She should be encouraged to keep about, for if she once gets down it is hard to get her about again. Her diet should be nutritious and sustaining. Large quantities of milk and eggs should be its basis.

Medicines apparently have but little effect. Methylthionin hydrochlorid in gr. ii to gr. vi daily, as recently suggested by Jacobi, has seemed to me to delay the progress of the disease. Where it is given the patient should be warned of its influence in discoloring the urine, or she will think dire occurrences are taking place in her kidneys. A times comes sooner or later in the life of every such individual when she must resort to opium in some form for relief. When circumstances are such that the patient can be kept under control it is best given as morphine hypodermically, but should never be self-administered. Care must be exercised to conserve the drug so that it will still be useful in moderate doses in the last stages when it is most needed.

Dr. E. S. McKee, of Cincinnati, on account of his recent medico-legal writings has been made a member of the Medico-Legal Society of New York and one of the editors of the New York Medico-Legal Journal.

Frank G. Ryan, Successor to Theodore D. Buhl.—At a meeting of the board of directors held Tuesday, April 16, Frank G. Ryan was elected president of the house of Parke, Davis & Co., Detroit, Mich., to succeed Theodore D. Buhl, recently deceased.

Venereal Prophylaxis in German Technical Schools.—By recent ministerial decree the directors of the German technical schools are instructed to make provision to have the medical inspectors of the schools give instruction in sexual hygiene at the beginning of the school year.

Plague in Hawaii.—Four cases of bubonic plague are reported in Honolulu, with three deaths. All the patients were Japanese and on the same plantation. Samples of imported oriental foods were examined, but no clue to the infection was obtained. Several rats had died on the plantation and their bodies had been burned.

Lord Lister's Eightieth Birthday.—April 5, 1907, Lord Lister, or as he was better known to the doctor, Sir Jospeh Lister, celebrated his eightieth birthday. He was the recipient of an immense number of messages from all over the world of a congratulatory character. At a meeting of the profession at the Royal College of Surgeons of England, the subject of the most fitting way of commemorating this auspicious event led to the decision to republish Lord Lister's scientific papers in a substantial collection.

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OFFICIAL TRANSACTIONS.

A NEW SIMPLE TECHNIQUE FOR CIRCUMCISION AND SOME ADVANTAGES GAINED IN GENITO-URINARY WORK—A PRACTICAL DEMONSTRATION OF THE TECHNIQUE.

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ST. LOUIS.

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THE operation of circumcision is performed in the venereal ward of the Emergency Hospital to meet a number of indications and to gain numerous advantages. It increases the condition of sexual cleanliness in those patients not suffering from local disease; promotes local cleanliness in those having local lesions, such as purulent urethritis and ulcers located in such a position to permit of operation, and produces a better nervous and mental constitution by removing all irritation about the glans penis, thereby ofttimes diverting the mental processes from unhealthy stimulation.

All patients entering the venereal ward are circumcised if possible to obtain their consent, and this is rarely refused. The old patients in the ward quickly inform the new comer that it has made them feel much better, has not caused any severe pain, and that they are recovering rapidly from their original complaints. It is proven by experience that patients suffering from urethritis and venereal sores, recover in less time than without the operation, and are consequently incapacitated for a shorter period of time, after circumcision has been done.

We operate on both "simple" and "complicated" cases, considering those as simple, which have no local lesions, and those as complicated, which have local disorders, such as purulent urethritis, ulcers, etc.

Our object in operating on simple cases, is to improve sexual cleanliness, improve the general nerve tonicity and remove certain morbid mental stimulants. Our object in operating on complicated cases is to aid the patient in a rapid recovery and have him leave the hospital with a better impression of sexual hygiene and with less chance of contracting and disseminating venereal diseases.

Those patients having urethral discharges are circumcised at once in order to remove all hindrances for proper drainage and to prevent the accumulation of inspissated infectious materials which may again be introduced into the urethra by injections and by contiguity of tissue. It is considered a matter of common surgical judgment, that contamination of the mucosa of the glans and prepuce by dried pus containing virulent organisms, is not a condition conducive to rapid recovery any more than allowing pus to collect and dry around any wound or ulcer on the general body surface.

Those patients having venereal sores are circumcised at the earliest opportunity after the ulcer is in condition to permit. If the sore is hidden by a long swollen prepuce, a slit is made (under 1% cocain or 2% eucain local anesthetic) at such a point and as near opposite the sore as possible to allow the prepuce to be pulled entirely back, thereby exposing the entire mucous and diseased surface. If the ulcerated surface is angry and contains a virulent infection, the sore is treated locally by packs until a healthier condition obtains. These packs are usually of bichloride of mercury or permanganate of potash, and are kept moist by covering with gutta percha tissue. It has not been found necessary to have the infection entirely disappear, and if it appears at a standstill or on a rapid decline, the operation is done without waiting for further healing. When the ulcer is in such a position as to prevent the line of incision from passing between the corona and the sore, it is treated locally till sufficiently healed to allow a complete removal with the prepuce. If the sore is specific, the patient is informed thoroughly as to what symptoms to look for and is not given specific treatment till the diagnosis is confirmed.

It was found in many cases that the patient needed circumcision, and that the usual clamp or dorsal slit methods were not useful on account of the indurated or ulcerated condition of the prepuce, causing it to re-

main entirely behind the corona. It was to meet such a condition that a technique which will be described below was devised.

In devising a method and technique, it was the aim to make the operation simple and easy of performance (requiring only the operator) and to eliminate all "special clamps and instruments," and to reduce the number of instruments required to the minimum. It was also the aim to make cleanliness a first consideration, and to eliminate pain as much as possible and to provide an operation which is short, and produces a neat, thorough coaptation of the wound edges.

Thorough cleansing of the field of operation is of paramount importance. The pubes and thighs are shaved and thoroughly cleansed with soap and water, followed by alcohol and ether. The penis is surrounded by a sterile towel 36 inches square with a 4 inch slit in the middle, moistened in 1-1000 bichloride solution. The towel extends from the middle of the thighs to well upon the abdomen. This provides an aseptic and antiseptic field, and moistening prevents the cloth from slipping about. The operator prepares as for any aseptic operation.

The necessary paraphernalia for the operation are: a pair of sharp scissors (curved or straight, and preferably about $5\frac{1}{2}$ inches long), a sharp needle; hypodermic syringe and needle; suture material, medium-sized catgut or silk, and a thin piece of gauze 3 inches long with a knot tied in one end. Everything is thoroughly sterilized.

Everything being clean and conveniently placed, the patient is placed on the table, and the field of operation prepared, as mentioned above. In simple cases, the moist towel is placed in position and the penis is drawn through the slit, and a thin piece of gauze moistened in bichloride solution is tied in a single knot around the base of the penis. (The knot is tightened after the anesthetic is injected.) The prepuce is allowed to assume its natural position without stretching. The first line of injection with a clean 1% solution of cocain, or 2% eucain is began, posterior to the ridge caused by the corona, on the dorsum. This line of injection is made circularly and in a direct line around the penis, an extra amount of fluid being injected longitudinally towards the corona in the median raphe. The prepuce is rolled back, so as to fully expose the mucous surfaces, and a second line of injection made about one-fourth inch posterior to the corona, beginning on the dorsum and extending entirely around, again giving special attention to the frenum. The knot at the base of the penis is now tightened so as to produce moderate constriction. Slipping of the knot can be prevented by moistening the strip in the 1-1000 bichloride solution. The step of anesthetizing requires about two minutes, and if properly done, pain need not be caused after the first insertion of the needle.

The penis is grasped in such a manner by the left hand, the operator standing on left side of patient, as to expose the *anterior* of injection, and a line of incision, allowing a width of about one-sixth inch of mucous membrane to remain, is made entirely around the penis, parallel with the corona, with a pair of scissors used with the right hand of the operator. The scissors are held at right angles to the surface in making the first cut, and afterwards held at a very acute angle, allowing a portion of the scissors to project under the uncut membrane. This is easy because the cellular tissue can be readily pushed in front of the blade. The scissors need not be removed from the wound till it is complete. The frenum is cut close, allowing

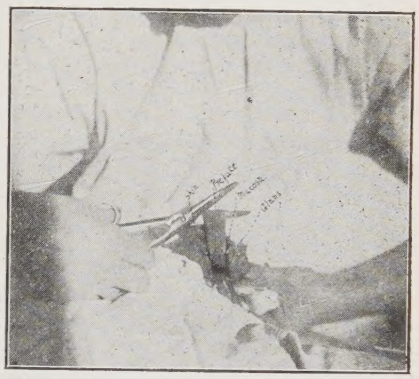

PLATE I. Cutting the band preparatory to dissecting off the prepuce and cellular tissue en masse.

about one-eighth to one-tenth inch to remain. The line of incision is made clean and deep down to the thick fascia, care being taken not to injure the urethra. The cellular tissue is cut free from the penis, by laying the scissors flat against the penis, for the distance of one-half inch back from the corona.

The prepuce is now brought forward, no attention being given to any bleeding which may have been caused. Free bleeding is rather encouraged at this stage, because it can do no more than carry out infectious material, and this is desirable in all cases, and especially those which are complicated by sores. A second line of incision is made in the skin, parallel with the corona in the center of the posterior line of anesthesia. This incision extends down to the thick fascia. We now have a band of tissue loose at both edges (Plate I), and it is lifted between the fingers, and cut transversely

with the scissors. One cut end is grasped and the cellular tissue and the skin dissected entirely around the penis. When this band is severed, the redundant tissue has been removed en masse and the clean, smooth edges are ready for approximation after attending to all bleeding points. Vessels of any size are grasped between the finger nails and crushed, or twisted with artery forceps, if necessary. The removal of the cellular tissue has created a space into which bleeding can occur if the two or three vessels are not crushed. When the sewing is nearly completed, the clots may be well squeezed out, and any further bleeding prevented by a moderately firm bandage. Swelling need not and does not occur unless caused by a too firmly placed bandage.

The capillary bleeding soon ceases and is usually stopped by the time the suturing is nearly finished, if not, the last suture is placed and not tied till the penis is grasped in a piece of gauze and rolled in such a manner as to squeeze out clots and produce firm pressure—this is always done as a matter of routine, because it helps adjust the wound edges and sutures.

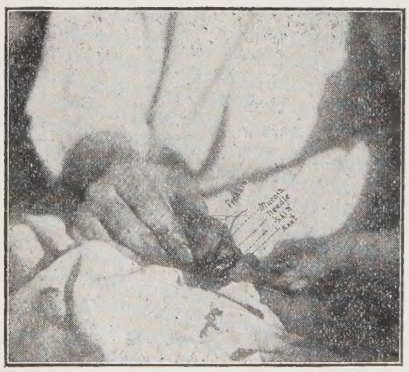

PLATE II. Placing the first suture, the needle is received, after passing through the mucous surface and skin in the gauze knot held firmly between the thumb and index finger.

When suturing, the strip of gauze with the knot (see Plate III) tied in the end is grasped in the left hand with the knot held securely between the thumb and index finger. The operator standing on the left side of the patient, lays the end of the penis on the pubes and supports the cut edges of the frenum while it is being pierced by the needle (Plate II), the knot being held in such a manner as to support the edges to be pierced and receive the point of the needle after passing through the tissue. Then the knot is lifted out and set to one side of the needle point while the needle is drawn through, and this same process is repeated with the skin edge—the first suture being placed in the median line in the raphe, the knot supporting the skin edge while the needle pierces from within outwards.

The suture is tied with a knot drawn tight enough to just approximate the tissue edges. The line of suture material attached, to the needle, is drawn below the tissue margins to be sutured, and the above mentioned manner of using the "gauze knot" is repeated and the needle passed in such a manner as to produce a continuous chain stitch suture entirely

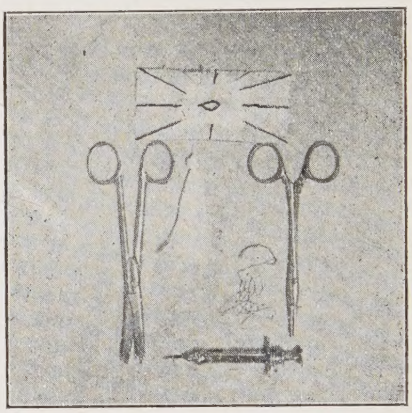

PLATE III. Materials and instruments used: Hypodermic syringe, needle and suture material, artery forceps, scissors, the "gauze knot" and "adhesive strip" cut ready for finishing the dressing.

around the penis. The sutures are placed at such a distance from each other as to produce a good even approximation. The last suture is tied to the end of the first, after rolling the penis in a gauze strip to squeeze out all clots and to adjust the sutures. The suturing need not be continuous, and the gauze knot is just as convenient for applying interrupted sutures, but any one familiar with suturing can do much quicker work, and the chain stitch produces a perfect coaptation.

The technique of preparing complicated cases, varies with the condition, but the technique of operation remains the same, only in phimoses cases which require a dorsal slit to be made before thorough cleansing and anesthetizing can be done. When there is a urethral discharge, the urethra is first thoroughly irrigated and the meatus dried and covered temporarily with a very small piece of sterile cotton held in place by flexible collodion or compound tincture of benzoin. The field of operation is again cleansed and the penis drawn through a slit in the center of a moist sterile towel. The operation is done and the cotton removed after the dressing is applied.

Patients having venereal sores are prepared by first decreasing the virulence of the infec-

tion, as described above, and then thoroughly washing the entire surface with 1-1000 bichloride solution. A thin long strip of gauze is saturated with the solution and wrapped around the penis so as to just cover the sores. Two or three turns of the antiseptic tape are made a clean narrow strip of gutta percha is applied and the wrapping is continued so as to cover the impervious tissue. The tape is slit at the end and tied loosely. The operation is performed as in simple cases, care being taking not to uncover the infected area, or to cut through it when cutting the band. The constricting band at the base of the penis is cut before placing the sutures so as to be able to detect all bleeding points. The entire operation need not require over eight or ten minutes, and one familiar with the technique can perform it easily in six to seven minutes.

It is essential in dressing circumcisions that several objects be accomplished, viz., that the dressing be sterile, light, impervious, and one that does not cause pain on removal.

After tying the last knot at the frenum, the penis is rolled firmly and a narrow strip of sterile gauze is wrapped around the penis covering the wound and extending well down the body of the penis. The strip is drawn rather firm and a clean piece of gutta percha tissue five inches square with a small hole in the center corresponding with the meatus is placed on the corona and wrapped in such a manner as to cover the entire penis. The tissue is melted down with a piece of gauze dipped in ether or boiling hot water. Over this tissue a bandage is applied, narrow adhesive strips being interspersed between the turns in such a manner as to prevent the bandage from slipping off, and also to hold the end of the penis well up against the abdomen. The adhesive strips extend from the corona to the middle of the abdomen, one in the center and one on either side. A piece of adhesive plaster cut as represented in Plate III is placed over the bandage.

This dressing is quickly and easily applied and keeps the field of operation clean. There is always a certain amount of serous secretion which is retained by the gutta percha tissue, making a moist dressing which should be removed after three or four days, and be replaced by a sterile gauze dressing. Removal of the first dressing does not cause pain and the patient need not be deterred from his usual duties.

As a matter of routine, all patients having been circumcised are given hypnotics for the first night or two. This usually consists of bromides or chloral. The chloral is given in two doses, one of 10 gr. followed in two hours by a 5 gr. dose. This gives the patient freedom from unrest and discomfort usually following operations of this kind.

This technique has given extremely good results, infections are rare, and the scar is smooth, and without any projecting papillae, and one familiar with the technique can get along nicely without an assistant.

1234 N. 14th street.

DISCUSSION.

Dr. C. E. Burford.—We have heard a good paper and seen a very nice demonstration. I think the knot in the gauze against which the needle is pressed has much advantage, especially in a case of this kind where one wishes to avoid pricking the finger. His stitch I do not think is applicable in all cases. I saw a case of chancroid in the City Hospital in which the condition spread all around the penis following the course of a continuous suture causing considerable trouble. Because of the tightness of the dressing, if the patient is on his feet very much there might be a constriction which might be followed by gangrene of the glans. I recall one case at the City Hospital where I tied no vessels. On attempting to urinate there was considerable bleeding, and finally we had to take the patient down to the operating-room and take out a clot which was about the size of a lemon. About the length of the skin, I think that is a minor point. I would prefer to leave the mucous membrane slightly longer than the doctor leaves it. The operation is very nice, but I believe the dressing is too tight. That might be all right in hospital cases, but if a man were walking about all day there might be interference with the circulation. Another point is his infiltration. I think that might be improved upon. Dr. Lewis has a curved blunt needle long enough to reach all the way around the penis. A slight incision is made on the dorsum and then the needle is easily carried around between skin and mucous membrane, and the anesthetic is injected as the needle is withdrawn. This is repeated on the other side and gives a very quick and beautiful anesthesia. This avoids the necessity for puncturing up the skin. We have been using alypin and it gives a very nice anesthesia. I have seen some sloughs occur following eucaine. A one or two per cent solution of alypin gives a good anesthesia. The doctor's operation is a very ingenious one, and there are many points about it that I like.

Dr. E. A. Scharff.—I want to congratulate the doctor on his paper, his nice, clean methods and the results so far. I agree with Dr. Burford as to the manner of cutting the mucous membrane. I have also seen quite a

few sloughs from eucaine anesthesia. I do not think it makes very much difference what anesthetic we use in these cases, even sterile water may give the effect. I also think that the dressing may be a little too close fitting, and might cause edema from pressure.

Dr. Henry Jacobson.—The operation is of course not a new one. The dressing is quite unique. I also use alypin in place of cocaine or eucaine. The rabbis in doing this operation on babies do not use any anesthetic at all. The child is simply held in the knees of some old man and the rabbi uses something like a little tongue-tied spatula with slit in centre in doing the work. They slip the foreskin through the narrow opening of the spatula with a knife and clip it off, and then with their fingers they tear apart the mucous membrane. It is surprising the results they get with few infections. In the children I use the tight prepuce forceps and cut off the skin and mucous membrane with the scissors and don't stitch it. Unless you have a trained nurse to watch the wound it does not do well, and under four years union is good without stitches. Dress the parts with gauze saturated with tincture of benzoin or aristol collodion. If there is an infection from the catgut sutures you get an irregular surface. In older patients I use an interrupted suture with silkworm gut, puting in about four stitches. The danger of suppuration is less with silk-worm gut if the dressings become disturbed.

Dr. Louis Rassieur.—I believe the old operation of making a dorsal slit and then cutting away a triangular flap on each side does equally as well. If there is any sore I think it better not to do any suturing, and the healing will be far more rapid.

Dr. Louis Drechsler.—I do not believe that the frenum should be sacrificed. It has always been my custom to preserve it.

Dr. Frank Hinchey.—I think that is a good point in the operation. I saw a case several years ago in which the frenum had been left, and it caused much trouble during erection and had to be cut.

Dr. Jacobson.—In these cases of chancroid I find it better to use the thermocautery and destroy the chancroid before proceeding with the operation.

Dr. Shutt, in closing.—Dr. Burford spoke of the tight dressing. The bandage on this patient is snug, but I do not think that it is too tight. The edema is done away with in this operation. The areolar tissue is removed far back and I do not remember a single instance in which edema followed the operation. It is true that if the patient has to be on his feet a great deal there might be some constriction and edema far back on the penis. As to the mucosa being cut short, there was at one time a sore which healed leaving a fibrous area. For that reason, I deemed it best to cut the mucosa close.

We have been using only cocaine and eucaine for anesthesia, and I recall that several times we have had sloughs following eucaine anesthesias. In doing this operation on children we have had just as nice results as on adults. As to the suture, if you can use a "chain stitch" and should get an edema, because some areolar tissue is allowed to remain, the nature of the stitch gives an opportunity for considerable expansion. The kind of suture, of course, is a matter of personal preference. The gauze knot is of great aid in applying any kind of suture about the penis.

I did not attempt this operation with speed, wishing to demonstrate each particular step, but have performed it several times in five or six minutes from the beginning of the anesthesia to the end of the operation. In such an operation it is not necessary to have great speed. Perhaps we can do the other operations just as quickly, but the result is a matter of considerable importance.

I do not think it advisable to allow the frenum to remain. Not long ago we had at the hospital a young man who wanted to be circumcised, and he brought with him a friend who had been circumcised by another method. The frenum had been preserved, and it was found that on either side of it there was a constantly moist pocket. So long as you have this moist pocket there is a field very susceptible to infection. The operation should provide for smooth, clean dry surfaces. Surfaces which will not become moist and remain so, thereby defeating in part the object of the operation. We have never had any complaints from the hundred and fifty odd patients who have been operated and the frenum removed.

REPORT OF A CASE OF BROW-PRESENTATION WITH AN INTERESTING FEATURE.

FRANK HINCHEY, M. D.

ST. LOUIS.

I DESIRE to report this case because of the use of a device which was of value in terminating a difficult delivery, when the customary resources had been of no avail. The credit for first calling attention to this aid is

due entirely to Dr. Fred J. Taussig, who described the principle of the technique in a paper read before this society on November 3d, 1904. Proof of its utility is shown when I say there was no effort on my part to hastily put in practice a device, the virtue of which I wished to test. On the contrary, I had completely forgotten the idea and faithfully tried every resource my knowledge afforded. Finally flexion of the head was attained by the only way which seemed possible, and it was only after calmly reconsidering the case on the following day, that the thought occurred to me where I had received the idea. To my mind this unconscious testimony, if I may so term it, is the most convincing proof of the device which Dr. Taussig has described.

The patient was a primipara, aged 23, who had been referred to me by Dr. S. L. Gettys. Her husband called upon me December 8, 1906, and informed me that his wife was suffering with irregular pains and was very nervous. From the data he gave, and the information from Dr. Gettys, she was then about eight months pregnant, and I felt safe in prescribing for false labor pains. I saw her the next morning for the first time. Pains had kept her awake from about midnight, and were short in duration and appearing at quite long intervals. By external examination I diagnosed right occipito-iliac anterior presentation with the head not yet engaged in the pelvis. After she had been in labor about fourteen hours I made vaginal examination. Cervix was rather high in the pelvis and dilated only about 2 cm., while lower uterine segment was rather dense. The head was rather firmly engaged and the tense bag of waters filled the canal. At this time, and even at a later stage no effort was made to locate the fontanelles, because of the desire to preserve the bag of waters. I believed I simply had to deal with a slowly dilating cervix—a rather unyielding lower uterine segment, perhaps due to short and unsatisfactory pains. Two large doses of quinine seemed to strengthen the pains, and eighteen hours after labor had begun a second examination was made and cervix found to have dilated to about 4 or 5 cm. A full dose of morphine was then given and patient slept two hours, but on awakening pains were again unsatisfactory, and under full anesthesia an effort was made to dilate manually, but with only slight success, as the tissues continued rather dense and unyielding. When the patient had been in labor about twenty-four hours, Dr. M. R. Horwitz was called to attend to the anesthesia. The patient was very nervous, almost hysterical, and further delay seemed undesirable. Patient was placed upon a table and prepared for forceps delivery. As soon as the bag of waters was cut all the amniotic fluid rapidly escaped. The diagnosis of brow presentation was then made. Without removing the hand an effort was made to flex the head by pressure against the brow, but without success. The small size of the head permitted a finger to be placed on each superior maxilla, and a second effort made with no better success. The hand was then passed into the uterus, and one foot was grasped in the attempt to perform version. This also failed as the uterus contracted tetanically, holding the fetus so firmly that I feared the exertion of much force would cause a rupture of the uterus. Forceps were then applied to the sides of the head and an effort made to forcibly flex the head, but this did not succeed, for when the forceps were locked the handles were almost against the perineum and could not be depressed sufficiently. After several efforts with the forceps the hand was again passed into the vagina, and with fingers placed on the upper edges of the orbital fossae an effort was made to change the position to face presentation; the intention then being to permit the patient to awaken, and for subsequent pains to effect the delivery. The position could not be changed. It then occurred to me that my efforts were nullified because of the fact that in the cramped space in which my hand was working my efforts to press the brow upward, or to draw it downward must principally crowd the occiput tightly against the pubes, thus prohibiting all movement. To offset this defect one blade of the forceps was entered along the side of the head and then turned until it passed between the occiput and pubes. This blade was grasped in the left hand, and while making pressure against the occiput with it, two fingers were pressed against the superior maxillae. At once the head was flexed. The forceps were then applied in the usual way and delivery quickly effected, at the expense of a perineal tear to the second degree. The child was cyanotic and did not respire, but after the usual manipulations was restored. After delivery of the placenta, in which the cord was marginally inserted, a ½% lysol douche was given and the perineal tear repaired. Aside from a temperature reaching to 101.2 at intervals for a few days, convalescence was uneventful. The child was small and apparently not full term.

In Dr. Taussig's case he exerted pressure against the brow. I do not know whether his would have sufficed in my case. The child in his case was permature (about three weeks) and it may be possible that if he had been able to exert counter-pressure against the su-

perior maxillae his efforts would have been successful. He also believes it essential that an assistant "should simultaneously exert pressure abdominally to push the chest of the child backward and breech forward" (Courier of Medicine, March, 1905). In my case this was not done and in the condition of the uterus being tightly contracted upon the fetus, I doubt if it would have aided.

DISCUSSION.

Dr. F. Reder.—These presentations fortunately are very rare. In my obstetrical experience I have not had a case of brow presentation. I have had a few face presentations. It is a brow presentation that is usually converted by natural means into a face presentation. The obstacles presented by a face presentation are severe, but the obstacles presented by a brow presentation, where the head remains midway between complete extension and complete flexion throughout labor, are serious. The danger to the life of the child is very great, and it requires competent management to insure the safety of the mother. It almost seems that nature unable to change the presentation, has taken recourse to avert disaster by allowing labor to take place prematurely in many of these cases. I doubt that in this case had the period of gestation gone to the normal time, whether the doctor would have been so fortunate as to convert the brow into a vertex presentation. This is one of the presentations where it is absolutely necessary that a correct diagnosis be made before the brow becomes engaged. It is before engagement of the brow that the good can be done. Many of these manual rectipositions are disappointing. However if a brow can be converted into a vertex, it is the best treatment for this kind of labor. I wish to state here that if the conversion was successful the flexion must be maintained till engagement has taken place, otherwise the vertex presentation will revert to a brow presentation. Suppose the doctor had not been able to convert the brow into a vertex presentation, what would have been the next thing to do? Forceps are of little avail, and absolutely harmful when the chin is posterior. Version can only rarely be performed in these cases. In symphysiotomy we can place our only hope, and it should be seriously considered. If the fetus is dead, craniotomy should be performed.

Dr. W. C. Gayler.—Earlier in the case it might have been possible to have so changed the position as to enable the doctor to grasp the foot and then bring down the child.

Dr. Kirchner.—I would emphasize the danger of rupturing the uterus. Dr. Brown operated on a case sent to the City Hospital in which there had been difficult labor, the forceps having been used and the child forced through the uterus into the abdominal cavity. Abdominal section was done, the child removed, and a panhysterectomy done. The mother made an uninterrupted recovery.

Dr. Hinchey, in closing.—There was very little dilatation. It was very difficult to apply the forceps through the small, rigid opening. I have hardly any doubt that if the woman had permitted labor to go on that the cervix would have softened, and this would have been converted into a face presentation. But the woman had been in labor twenty-four hours, the household was in disorder, the woman was hysterical and her friends thought she was going to die, she was growing weaker and was a very difficult patient to manage. If I had not done something effectual without more delay somebody else would have done it. As Dr. Reder has said, it was a question what would have to be done if the case did not terminate satisfactorily. I was at my wits' end, as I thought of the possibility of having to send the patient to the hospital, for a symphysiotomy, Cesarean section, or something of the kind.

Dr. Reder.—Do you know the proportion of brow presentations?

Dr. Hinchey.—I think various statistics are given, ranging from 1 in 1700 to 1 in 2500; that is, where they remain permanently brow presentations.

THE thirty-second annual meeting of the American Academy of Medicine will be held at the Hotel Dennis, Atlantic City, June 1, and Monday, June 3, 1907. The president, Dr. C. A. Wood, of Chicago, has selected for his annual address "A Medical Career and the Intellectual Life."

HELLER'S TEST.—Sachse suggests an improvement in the technique for Heller's test for albumin. A glass slide is laid on a black surface; on this are placed, side by side, a drop of urine and one of nitric acid. If the reaction is positive at the line of junction of the two drops, a characteristic film of albumin will form, and gradually a milky veil spreads over the fluid, which can be clearly discerned against the black background. This modification is extremely simple and delicate, and only minute quantities of urine and reagent are needed.

THE MEDICAL FORTNIGHTLY

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EDITORIAL

A New Crop of Doctors.

THE commencement season is well advanced and nearly all of our local medical schools have already launched a new crop of physicians on the suffering public. We have not the figures for the number graduated in St. Louis, but the American Medical Council announces from Chicago that about 4000 graduate in America each year, of whom 3000, it says, are not properly equipped. We are not prepared to accept this statement, except on the ground that we have an already overcrowded profession and entrance must be made difficult, that the supply may not hopelessly surpass the demand. We feel certain that the class of 1907 in every school in the country is the strongest ever graduated, and is better able to undertake its work than any which have gone before. Medical education in St. Louis is taking rapid strides, the training offered has been improved so rapidly that those who graduated a decade or two ago would be utterly lost in the new atmoshpere. Better preliminary requirements, a four-year's course and a general elimination of untrained teachers have worked marvels in the university schools, and have made us proud of the work done and the graduates turned out. There has been a considerable decrease in the number of schools here, and a further decrease would work no hardship on the public or profession, there is no chance that there will not be physicians enough even though fewer graduate. But is it wrong to reflect on the fitness of three-fourths of the men graduated these days just because we do not see that they are needed. These men are vastly better equipped than we were at the time of our graduation, and the only criticism we could make of their preparation is that it leaves them with an *ultra-scientific* bias which better fits them for work in large hospitals and laboratories than for the emergencies of the average country practice.

Chicago's Mayor Sets a Good Precedent.

WE are pleased that our mayor has so ably handled the difficult question of his medical appointments, but we are impressed that he might have saved himself a considerable amount of trouble in arriving at his conclusion had he adopted the wise plan of Mayor Busse of Chicago. Before making his appointments Mayor Busse announced that his purpose was as follows:

"In regard to the appointment of a commissioner of health, I intend to consult with a number of well-known citizens, perhaps twelve or fifteen, including such men as Drs. Robert B. Preble, Nicholas Senn, John B. Murphy and Frank Billings. Let us have a good commissioner of health this time. I want to take the physicians into a partnership of responsibility with me, so that if an epidemic breaks out we will have a medical man toward whom the physicians of Chicago stand in the attitude of cooperation and not as his critics."

Pursuant with this plan the committee was appointed, it was compoesd of twenty-six physicians, all men prominent in medical affairs. Of these but nineteen were able to be present at the conference at which they selected Dr. Wm. A. Evans, whose appointment followed. It is up to Dr. Evans to show the American cities that Mayor Busse has discovered the proper procedure in the matter of selecting medical appointees. We believe that he has.

The Charity Carnival.

THE carnival given at Delmar Garden on the afternoon and evening of May 10th was the most successful event of its kind which ever took place in St. Louis, something like $40,000 having been raised for division between the Salvation Army Nursery and the St. Louis Skin and Cancer Hospital. The affair was engineered by a group of society ladies under the chairmanship of Mrs. Frank V. Hammar, and was the society event of no small importance. Aside from all which may be said of the worthiness of the object of the carnival there are many reasons for commending the undertaking and comparing it with other methods of money raising for like purposes, notably the Saturday and Sunday Hospital

Collections. The carnival was well conducted, there was an absence of over-solicitation and extortion, which was pleasantly surprising, and those who invested got a direct return for their money which was entirely satisfying, and left none of the sensation of a hold-up, such as we experience in the collection each fall. The financial success of the day and our own sensation in connection therewith entirely converted us to this method of money raising, and we would recommend it to the consideration of the Hospital Saturday and Sunday Association.

The Salvation Army Nursery and the Skin and Cancer Hospital are charities of such importance, and are doing such a beneficient work that it should be a matter of general self-congratulation that so goodly a sum has been placed at their command, and that it was so easily and quickly raised. We commend the suggestion that it become a regular feature of the support of these institutions.

The A. M. A. Excursion to Atlantic City.

This year's meeting of the American Medical Association has been very thoroughly presented to the profession and further announcement of details seems superfluous at this late day. Yet there are always those who are unable to decide about going until the very day of departure and for them we would again call attention to plans for the trip via the Big Four and Chesapeake and Ohio. Many of the St. Louis delegation were apprehensive that the original plan would make connections so close as to make possible a consequent delay in arriving at our destination on Monday. To eliminate any such chance, a party will leave on the regular train at 11:25 p.m., Friday, May 31st, arriving at Atlantic City early Sunday afternoon; the second party will join the Missouri Valley Excursion leaving St. Louis via the Big Four at noon Saturday, June 1st, stopping at Hot Springs, and reaching Atlantic City Monday forenoon. The A. M. A. proper opens on Tuesday morning, but there are a number of auxiliary societies that hold their meetings on Monday, as well as the sessions of the House of Delegates. Abundant Pullman service and every convenience are at our command, and the time spent en route promises to be not the least pleasurable part of the trip. We are informed that accommodations are still to be had at the Grand Atlantic, though this house is rapidly filling, as is natural, considering its central location. Physicians who have not secured quarters in advance will do well to apply at the Grand Atlantic, and if accommodations are not to be had there it is a central point from which to operate and temporary quarters are certain to be found in the vicinity.

Dr. A. H. Myerdick, of 3216 Laclede avenue, has been appointed assistant dispensary physician by Health Commissioner Bond, to succeed Dr. Arthur Friedeberg who resigned after two days' service because he learned that he could not serve on account of having never been naturalized.

The following officers have been elected to manage the affairs of the Missouri Association for the Relief and Control of Tuberculosis, which was made a permanent organization at a recent meeting: Dr. George Homan, president; Robert J. Newton, secretary; J. H. Lynch, treasurer.

Dr. Edith Strong.—Among the recent medical graduates from our local schools are a few in whom we are particularly interested and in whose success we feel a friendly pride, prominent among these is Miss Edith Strong who has some time served the St. Louis profession as a medical stenographer, and has been very closely identified with the profession. Our congratulations to Dr. Strong.

Our City Institutions.—The Mayor in making his recent appointments has done well by the St. Louis Medical Society, the medical appointees and the sub-appointments show a very flattering number of its members. We doubt if the society was ever before so largely represented at any one time. The society is not interested in politics, as such, but is interested in having our Health Department and the city institutions conducted on the very highest scientific plan, and feels a natural degree of satisfaction that its membership is the natural source of supply of suitable material for such appointments.

Resignation of Dean Bond.—After serving seventeen years as dean, first of the Marion-Sims Medical College, and later of the medical department of St. Louis University (of which the Sims became a part) Dr. Young H. Bond has found it necessary to resign and the institution has accepted the resignation with great regret Dr. Bond's foresight, insight and good judgment have been strong factors in making his institution the power that it is at present, and the influence of his long service will be permanently felt. His successor is Dr. E. P. Lyon who occupies the chair of Physiology, and who came to the university from the medical department of the University of Chicago (Rush).

MEDICAL MISCELLANY

TAUSSIG-GOTTSCHALK.—Dr. Fred J. Taussig and Miss Florence Gottschalk were married at Christ Church Cathedral in this city on May 4th. Dr. Taussig is one of the more prominent of the younger physicians of St. Louis, and is personally known to a considerable number of our readers who will join us in all manner of pleasant wishes on this happy occasion. Dr. and Mrs. Taussig have gone to Europe for the summer.

A CORRECTION.—We regret to call attention to an error which crept into Dr. Hassin's article in the last issue of the MEDICAL FORTNIGHTLY, which made the reading decidedly ambiguous. By a mistake of the printer the last line of the first column, on page 205 became transposed with the two top lines of the second column. The sentence should read: "and thus the practitioner neglects or misses the opportunity of applying at suitable time the radical treatment, losing precious time with lamentable results to the patient's health and life. This is particularly true for syphilitic affections of the central nervous system," etc.

THE ST. LOUIS SKIN AND CANCER HOSPITAL REPORT.—Since the establishment of the St. Louis Skin and Cancer Hospital in July 1905, 522 cases have come under the supervision of the institution, 439 of which were hospital cases. In the hospital 151 tissue and 288 organic examinations were made. During the first 18 months $15,323.92 was expended of the $15,605.94 on hand, leaving a cash balance of $283.02. The total amount of subscriptions promised is $46,495.10 and the cash on hand at the end of the fiscal year $8,196.02. The report shows that $12,500 additional is needed to carry out the work, for the remaining term of three and one-half years.

THE MISSOURI VALLEY A. M. A. EXCURSION.—Those who contemplate the trip to Atlantic City, are cordially invited to join the Missouri Valley party, which is made up of physicians and their families from Omaha, Kansas City, St. Joseph and other points in Iowa, Nebraska and Missouri. This train leaves St. Louis on Saturday, June 1, at noon, stopping at Hot Springs, Virginia, on Sunday, where the entire party will be entertained at luncheon, and arriving at Atlantic City on Monday morning in ample time to attend the meetings which precede the American Medical Association. The special car from Omaha will run via the Wabash, while those from St. Joseph and Kansas City will be via the Missouri Pacific. Parties at intermediate points may make reservations on this train, by applying to local agents, while those who reside on other lines of railway, may meet the special at St. Louis. Reservations for Pullman and hotel may be had by wiring the secretary, Dr. Chas. Wood Fassett, St. Joseph, Mo., before May 30th. The special cars leave the Missouri river points on evening of May 31.

As a result of the recent municipal elections in Illinois the following medical gentlemen have been elected or rejected for office: Dr. J. S. Collins was elected mayor of Carlinville, Dr. T. C. McCord was elected mayor of Paris, Dr. J. A. Wheeler was elected mayor of Auburn, Dr. J. C. Westervelt failed to be elected mayor of Shelbyville, Dr. Paul Allyn was elected alderman of Waverly, Dr. M. H. Goodrick was elected alderman of Jacksonville, Dr. J.W. D. Mayes was elected president of the school board of Illinois.

THE DEATH OF REV. JOHN WATSON.—Probably no recent writer of fiction has more ably pictured the physician of the old school than did Ian MacLaren; through his pen he made his Dr. MacLure a living, breathing character, whose influence is quite as real and lasting as that of mortal man. The death of the man who created Dr. MacLure occurred recently in a neighboring state and is deplored by the civilized world. It has seemed especially fitting that the medical profession should notice Dr. Watson's death and the matter was brought to the attention of the St. Louis Medical Society at a recent meeting by Dr. Homan in the following resolution which was unanimously adopted:

WHEREAS, In drawing the character of Dr. Weelum MacLure as a doctor of the old school Ian MacLaren paid a well-merited tribute to the integrity, faithfulness, and unselfishness of the medical profession—the justness and fidelity of which picture is evidenced by the early, wide and continued popularity of his book, "Beside the Bonnie Briar Bush;" therefore

Resolved, That the St. Louis Medical Society testifies its deep regret at the sudden demise of the author, Rev. John Watson, which occurred on the 6th instant, and in recognition of his service to our profession would earnestly recommend to all medical men a study of the character of Dr. Weelum MacLure, depicted in the writings of Ian MacLaren as a conspicuous example of the high standard of conscientiousness and devotion to duty which it is incumbent on all true physicians ever to uphold in their professional life and work.

THE REVIEWER'S TABLE

Books, Reprints, and Instruments for this department, should be sent to the Managing Editor, Century Building, St. Louis.

MODERN MEDICINE: ITS THEORY AND PRACTICE. In original contributions by American and Foreign Authors. Edited by William Osler, M. D., Regius Professor of Medicine in Oxford University, England; formerly Professor of Medicine in Johns Hopkins University, Baltimore, etc., assisted by Thomas McCrea, M. D., Associate Professor of Medicine and Clinical Therapeutics in Johns Hopkins University, Baltimore. In seven octavo volumes of about 1000 pages each. Illustrated. Volume I just ready. Philadelphia and New York: Lea Brothers & Co., 1907-1908. (Price per volume, cloth, $6.00 net; leather, $7.00 net; half morocco $7.50 net.)

This is the first volume of the work which may be said to be the crowning of Osler's literary career, and when completed promises to be one of the most important literary tasks ever undertaken in medicine. The editor and his well chosen corps of co-workers aim to present a work which is eminently practical in every detail, and at the same time enjoying a highly scientific aspect. They strive to keep an even balance between the condensation of the text-book and the elaborate treatment of the monograph, as Osler so admirably expresses himself in his introductory remarks: "It is designed primarily for the practitioner who wishes to keep himself informed of the existing state of our knowledge in clinical medicine. Elaborate discussions on doubtful problems have been avoided, and as far as possible, a clear statement is given without unnecessary references to literature. Our labors are in vain—all the manifest contributions of science, the incessant researches into the complex problems of life, normal and perverted, the profound and far-reaching conclusions of the thinkers and originators —all these are sounding brass and tinkling cymbals, unless they result in making men better able to fight the battle against disease, better equipped for their ministry of healing." The volume begins with an elaborate and interesting historical discourse, by the editor himself, on the evolution of internal medicine, beginning with pre-Hippocratic era and extending to modern times. Nine parts, subdivided into thirty-four chapters comprises this volume. Part I on Heredity and Predisposition is discussed by George Adami, of Montreal, in a very intelligent and logical manner. He emphatically asserts his convictions, which he substantiates by convincing arguments. Thus he says: "Gross mutilations are not transmitted. There is no such thing as inherited small-pox, inherited tuberculosis or hereditary syphilis, they are but post-conceptional acquirments. Parts II and III on Diseases Caused by Physical and Chemical Agents are written respectively by Alfred Gordon and David Edsall in an attractive and comprehensive style. Part IV considers thoroughly Diseases Caused by Organic Agents, 170 pages of interesting readable matter are devoted to this subject. The contributors are Alexander Lambert, who writes a chapter respectively on alcohol, and one on opium, morphinism and cocain. Frederick Novy writes an instructive chapter on food poisons. Hideyo Noguchi discusses snake venoms in a scholarly manner, while Alonzo Taylor's article on autointoxications is an expression of good judgment, and contains many useful suggestions to the general practitioner. James Wright writes two splendid chapters on Diseases Due to Vegetable Parasites other than Bacteria (Part V). Nearly 200 pages is given to Diseases Caused by Protozoa (Part VI). The subject is fully illustrated and written by men of vast experience. The contributors to this section are Gary Calkins, who writes on the protozoa; L. O. Howard on mosquitoes; Charles Graig, malarial fevers; J. W. Stephens, black water fever; Col. David Bruce, trypanosomiasis, and Richard Strong, amebic dysentery. Part VII by Charles Stiles, comprises over 100 pages on Diseases Caused by Animal Parasites. The subject Nutrition (Part VIII) dealing with an excellent consideration of metabolism, normal and in disease is written by Russell Chittenden and Lafayette Mendel, both men of wide experience. Part IX is devoted to an exhaustive and thorough consideration of Constitutional Diseases, incorporating diabetes mellitus, diabetes insipidus, gout, obesity, rickets and scurvy and is written respectively by such eminent writers as Thomas Futcher, James Anders, George Still and Robert Hutchison. The publishers are deserving of great credit for having done their part so well. We anxiously look forward to the appearance of the second volume, which Messrs. Lea Brothers & Co. promise to have ready in June.

ANNALS OF SURGERY FOR JUNE. Philadelphia: J. B. Lippincott Co., Publishers.

About two years ago Annals of Surgery published a special anniversary number, which, because of character and quantity of contents, gave the impression of a surgical text-book. It was a remarkable venture, and one seldom attempted by a medical journal and carried to a successful consummation. The venture will be repeated this coming month, when another special number is promised. This will contain exhaustive papers on Renal and Ureteral Calculus; Toxic Nephritis as Dependent upon Surgical Conditions; Tuberculosis of the Testicle; Primary Typhlitis without Appendicitis; Radical Cure of Inguinal Hernia with Local Anesthesia; Plastic Resection of the Mammary Gland; Acute Ulcer of the Stomach; Closure of Fecal Fistula; and a number of

other equally interesting subjects, the contributors will be the foremost American surgeon-writers. Regular subscribers will receive this number without extra cost. The price to others will be one dollar.

PARAFFIN IN SURGERY. A critical and clinical study by Wm. H. Luckett. M. D., Attending Surgeon to the Mt. Sinai Hospital Dispensary of New York, and Frank I. Horne, M. D., formerly Assistant Surgeon, Mt. Sinai Hospital Dispensary. Thirty-eight illustrations, 118 pages. New York City: Surgery Publishing Co., 92 William Street, (Cloth, $2.)

This book covers a special field in surgery of absorbing interest both to the surgeon and general practitioner. The research and original investigations made by these authors in the use of paraffin have exploded many fallacies previously maintained. It presents the chemistry of paraffin, the early disposition of paraffin in the tissues, physical state of paraffin bearing on its disposition, the ultimate disposition of paraffin, technic and armamentarium. It thoroughly covers the use paraffin in cosmetic work, such as saddle nose deformity, depressed scars, hemiatrophia facialis with a large number of photographs showing cases before and after operation, with illustrations of micro-photographs of the disposition of the paraffin in the tissues. It also presents other conditions of a functional character, where paraffin can be used with service such as inconsistency of urine, umbilical, hernia, umbilical and ventral hernia, epigastric hernia, inguinal hernia, etc. The subject is presented in a scientific yet comprehensive manner. Full details are given to the method of preparing the paraffin as well as the method and manner in which it should be injected. This book presents a wide field for the use of paraffin and a copy should be in every physician's library. It is printed upon heavy coated book paper and attractively bound in the best quality of heavy red cloth, stamped in gold.

A TEXT-BOOK OF THE PRACTICE OF MEDICINE. For Students and Practitioners. By Hobart Amory Hare. M. D., B.Sc., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia, etc. In one very handsome octavo volume of 1120 pages, with 131 engravings and 11 full-page plates in colors and monochrome. Second edition, revised and enlarged. Philadelphia and New York: Lea Brothers & Co., 1907. (Cloth, $5.00, net; leather, $6.00, net; half morocco, $6.50. net.)

A second edition of a text-book in a short period of two years sufficiently indicates the popularity of the work. The construction of this volume is identical to that of its predecessor, and embodies the experience of more than twenty-two years of active hospital practice. Although this edition is somewhat larger than the first it is devoid of any irrelevant matter for the purpose of padding. The author is timely, concise and very clear in his remarks, avoiding entirely uncertain and debatable questions. Illustrations are abundantly used to elucidate the text, thus affording a book eminently suitable for both student and practitioner.

GOLDEN RULE OF PEDIATRICS. By John Zahorsky, M. D. Pp. 362. St. Louis, Mo.: C. V. Mosby Medical Book and Publishing Co. (Cloth, $3.50.)

This volume is filled with aphorisms which are almost without exception important to every physician who does any pediatric work. We appreciate the wealth of good sound sense and of scientific truth covered, but we regret that the presentation had not been further elaborated and systematized, for much of the worth of the book is lost in its lack of cohesion and continuity. Every physician will find in the book many statements which, because of their briefness and directness, will make a lasting impression, and this is its purpose.

SURGERY OF GENITO-URINARY ORGANS. By J. S. Gouley, M. D. Demi octavo; 531 pages. New York: Rebman Company, 1907. (Price $3.00)

This book comes from a man with wide clinical experience, and presents the results of his researches combined with those of other authorities, in the nature, diagnosis and treatment of those genito-urinary disorders which come within the province of surgery. The matter presented is in a high degree practical, and the method of presentation is clean and clear, and the book is interesting reading in its every detail. A commendable feature is the chapter on catheters, sounds, etc. The selection and care of these instruments is too often a matter of ignorance which few texts have attempted to remedy; nowhere do we remember having seen so good a discussion of the subject. Four chapters are devoted to stricture, three to urinary retention, three to the prostate, two to uro-cystitis; while urethritis, orchitis, vesiculitis, bladder injuries, tumors, contracture, hemorrhage, saculation and calculus make up the subject matter. Dr. Gouley has a most pleasing style; he holds the attention closely and makes every word tell. We have seldom read a book which so entirely met with our approval and which we can so heartily recommend to our readers.

CREMATIONS IN GREAT BRITAIN.—The cremations carried out in Great Britain during the year 1906 were as follows: Golder's Green, N. W., 298; Woking 140; Manchester, 90; Glasgow, 44; Liverpool, 46; Hull, 17; Darlington, 13; Leicester, 12; Birmingham, 25; Leeds, 15; Ilford (City of London,) 23; Bradford, 13, and Sheffield, 6—making a total of 742. In 1905, the total was 604. The establishments at Hull, Leicester, Leeds, Ilford, Bradford and Sheffield are owned by municipal bodies.

REPORTS ON PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

SURGERY.

JOHN MCHALE DEAN, M. D.

Successful Resection of Over Twelve Feet of the Ilium.—Werelius (Jour. A. M. A., March 16), reports a case in which resection of twelve feet and two inches of the ilium was rendered necessary by perforation of the uterus and separation of the intestine from its mesentery during the induction of criminal abortion. When Dr. Werelius examined the patient he found an enormous length of the bowel, minus its mesentery, protruding from the vulva. An incision about three inches in length was made through the right rectus. The peritoneal cavity was found partly filled with blood, and a large amount of the mesentery, minus its bowel, presented in the field. The disattached bowel was felt to escape through a rent in the left broad ligament into the uterus. The hemorrhage seemed to come mainly from the injured broad ligament, and not, as one would suspect, from the mesentery as this was torn closely from the intestine and included the serosa. On account of some oozing from the border of the mesentery and to prevent future adhesions a suture was run along its edge. Then the gangrenous bowel, measuring twelve feet and two inches, was resected and withdrawn through the vagina. An end-to end anastomosis was made with a Murphy button. The uterus was was found to contain seven punctures. One extending through the left broad ligament was somewhat enlarged and the interior of the uterus inspected. The fetal head and part of the placenta had been left. These were removed and the uterus curetted through the enlarged opening. The uterine punctures were then sutured and after the peritoneal toilet and the establishment of drainage the abdomen was closed in layers. Saline solution was administered and the patient put in Fowler's position. On the afternoon of the next day her temperature was 102F. She was given an enema, 1 part magnesium sulphate, 2 parts glycerin and 3 parts water, with good results.

On the third day the wound discharged pus containing colon bacilli; this continued till the fourteenth day. The button was passed on the tenth day. During the entire course there was no tympanites. The diet was gradually increased till on the seventeenth day the patient was put on a regular diet. She was out of bed on the nineteenth day, and on the twenty-seventh day after the operation, she left the hospital. Two weeks afterwards she was troubled with a diarrhea, which lasted about two weeks. Later she went into the country where she improved quickly. Eight months after the operation she had gained 13 pounds, and had no symptoms of adhesions, or local tenderness.

Fractures.—Attention is called by Bowse (Brit. Med. Jour.) to the important modifications which have been introduced into the treatment of fractures. These new developments consist in the early employment of massage and movement, and a less absolute adherence to the traditional methods of immobilization; the application of operative measures to ordinary cases of simple fracture. The use of the X-rays has also introduced new factors. These modifications are due to the teachings of Lucas Championniere. The conception of prolonged immobilization as the dominant principle in the treatment of fracture was arrived at by a too exclusive attention to the injury to the bone, and a neglect of the associated injuries of the soft parts. Absolute immobility is not essential to body repair. The extremities of a broken rib unite rapidly despite the incessant respiratory movements, this taking place even where a portion of the rib has been removed by resection. On the other hand, nonunion is frequently observed in fractures of the cranial vault, where the bones are immovable. Immobilization in some form is necessary to secure union of marked displacement of the fragments, where the displacement tends to be reproduced after reduction. It is the displacement, however, and not the mobility, that interferes with union. The fear of displacement has been exaggerated; the fleshy bellies and the tendons of the muscles form a sleeve-like splint which tends to keep the bone in position. The strong fascia and connective tissue of the limb, and the insertions of the muscles, fascia and ligaments into the bones, all play a similar part. Immobilization entails certain hurtful consequences: wasting of the muscles, stiffness of the joints, weakness of the limb, and pain on attempting movement are usually to be observed when the splints are taken off. These disabilities are due to the treatment, not to the fracture. Associated with the atrophy of the muscles there is also a concurrent and consequent atrophy of the bones. Early massage and movement enable us to avoid many of the results of immobilization, and constitute the best treatment for repair of the fracture and restoration of the function. The massage to be applied differs entirely from that employed by professional masseurs. It consists in a smooth, soft, uni-

form, above all painless, mobile pressure in the direction of the venous current. At first just a touch, the degree of pressure is progressively increased so as to act gradually on the deeper structures. It should be practiced from the very beginning of treatment, and repeated daily for half an hour at a time. After massage, passive movements, before impossible because so painful, become surprisingly easy. Active and passive movements may be usefully combined. The first and most striking result of massage is the relief of pain. This is prompt and decided to a degree that is almost incredible. Swelling is also removed, the volume of the limb diminished, the tension relieved, absorption hastened, and normal circulation restored. Adhesions are prevented and the flexibility of the joints maintained. The adhesions do not form because the so-called plastic lymph which gives rise to them is removed by the massage. Voluntary movements are even more useful in preventing muscular atrophy than massage, as it excites the natural functional activity of the different associated parts of the motor apparatus: the muscle, the nerve, the nerve center. Finally, massage shortens the duration of treatment very considerably.

Ruptured Gastric Ulcer in a Boy.—Gastric ucler is rare in children; still rarer is ruptured gastric ulcer. In the Scottish Medical and Surgical Journal for September Dr. G. K. Paterson states that he has been able to find recorded only 14 cases of ruptured ulcer in children under the age of 14 years. He reports the following case: A boy, aged 12 years and 8 months, began to suffer from epigastric pain which occurred irreguarly with regard to meals, sometimes immediately after, sometimes half an hour after, sometimes two hours after, and sometimes not at all. Previously he had not suffered specially from any ailment except recurring laryngeal catarrh. pain was of a burning character and there was no gastric flatulence or vomiting. The tongue was silghtly furred. A light diet and remedies for dyspepsia were prescribed with little result. Twelve days after the onset, at about 7 p.m., after a light dinner he suddenly felt a severe pain in the abdomen. Dr. Patterson saw him an hour later and found him collapsed and pale, with slow pulse and rigid abdomen. There was no loss of liver dulness and the temperature was normal. He complained much of pain about the umbilicus and almost more of pain in the left shoulder, the latter being aggravated with each inspiration. The abdominal pain was relieved by a fomentation and gentle friction and all the symptoms of shock passed off in half an hour. The case looked like one of severe colic, but he shock and previous pain made Dr. Patterson doubtful. He gave instructions that he was to be sent for if the boy became worse. He saw the boy again next morning at 9 a.m. The patient had vomited at 9 p.m. on the previous evening and again in the night and there had been frequent retching. The abdominal pain became easier during the night. There were signs of peritonitis—distended abdomen, raised temperature, and loss of liver dulness. Eighteen hours after rupture laparotomy was performed by Mr. F. M. Caird. General peritonitis with a mass of lypmh over the liver and stomach, was found. When the lymph was separated a punched out ulcer of about the size of a split pea was found in the anterior wall of the stomach about two inches from the middle of the lesser curvature. A smear of peritoneal fluid was taken and showed a culture of staphylococci. The peritoneum was washed out and the lymph was swabbed off the surface of the liver and from the recto-vesical pouch. Nutrient enemata were given for three days and then mouth-feeding was begun. Convalescence was interrupted by a severe attack of double pneumonia which almost proved fatal. A case of perforation of a gastric ulcer in a boy, aged 13 years, has been recorded in our columns by Mr. Watson Cheyne and Dr. H. Wilbe. The pain and rigidity were most marked on the upper part of the right side. Fulminating appendicitis was diagnosed, but on operation a perforated gastric ulcer was found which was successfully sutured.—London Lancet.

Abdominal Drainage.—Coffey (Jour. A. M. A., March 16) has experimented with the various methods of abdominal drainage, more especially the physics of tubal and capillary abdominal drainage. By making careful sections of a cast of the abdominal cavity he demonstrated that the deepest situated portion of the abdominal cavity, in the supine position, is in the flank and that to drain properly from this into the pelvis would probably require the raising of the trunk at an angle of 60 or more degrees, while to drain the pelvis into the flanks would require the raising of the feet very high. In the lateral position, however, almost all the cavities can be drained. His general conclusions are stated by him substantially as follows: 1. Gravity is the chief factor in peritoneal drainage, therefore drainage must reach the most dependent portions. 2. Gauze or capillary drainage is the most widely appilcable and useful of all drains, if used in sufficient quantity to preclude its being choked by de-

bris, and provided the drain is as large in circumference at its exit as at any point within the cavity, and provided it is in contact with abundant dressings on the outside. 3. Gauze drainage is a very dangerous agent if the above principles are not kept in mind. 4. If a surgeon remembers that his drain ceases to be effective in a few hours, he places it with the idea of removing septic fluid in the shortest possible time according to the principles of drainage, and generally gets results. 5. If he has the delusion that his drain will continue to work for days and that the fluid will flow up hill to get it, he will probably be disappointed. 6. If he habitually removes gauze drains before they are naturally loosened, many of his patients will have secondary septic or postoperative hernia or obstruction. 7. Drainage (except a small precautionary cigarette or tubular drain) can rarely be safely removed before the fifth or sixth day. 8. Capillary drainage is inefficient for defined abscess cavities. 9. Tubular drainage is suitable for defined abscess cavities, and may be used for gravity drainage from the peritoneal cavity, but an uncertain drain in the peritoneum.

INTERNAL MEDICINE.

O. E. LADEMANN, M. D.

Notes on Six Thousand Cases of Neurasthenia.—Cleghorn (Medical Record, April 27, 1907) analyzes six thousand cases of neurasthenia treated in the neurological department at the Vanderbilt clinic during the years from October, 1888, to November, 1906. From this list are excluded cases which had any definite symptoms recorded of hysteria or insanity. No cases in children under thirteen years of age were found which could not be attributed to the ordinary nervousness brought on by fright or poor environment, though some of them might have been found to be neurasthenic had they been followed up for a sufficient time. Out of this number there were 3,516 or 58.6% males and 2,484 or 41.4% females. Cleghorn summarizes his paper as follows: Neurasthenia is much more frequent in men than in women. It occurs between the ages of 20 and 40 in two-thirds of the cases, few comparatively starting after 40. The indoor occupations furnish a large majority of all cases. Among causative factors, the disturbances of the gastro-intestinal tract and the intoxications stand out as principals, and the most constantly present symptoms seem to be headache, insomnia and constipation. Is this last mentioned condition really a cause or a result of the disease?

Tests for Acetone in the Urine.—Jackson Taylor (The Lancet, March 23, 1907) believes that the sodium-nitro-prussid test for acetone in the urine may be simplified and rendered more delicate and accurate by substituting strong ammonia for the liquor potassae, and by eliminating the use of acetic acid. In the ordinary test when the solution of potash is employed there is a uniform reddening of the whole solution which on the addition of acetic acid in the presence of acetone becomes darker when the acid comes in contact with the urine, the darkening passing down as the acid sinks. Therefore, with this test the addition of liquor potassae to the urine and sodium-nitro-prussid yields a red color whether acetone is present or not, and it is only after the final addition of acetic acid that the presence of acetone is recognized, and then only when there is a fair amount of the latter present. The detection of the presence of acetone is therefore dependent on the darkening of an already darkish red fluid by the final reagent, acetic acid, and the degree of darkening, when acetone is present in only small quantities, is not altogether easy to determine. The author suggests the modification as follows: On adding the ammonia to a solution of sodium nitro-prusside and urine the ammonia solution remains on top; thus there is a clear solution uppermost with the urine solution below. Should acetone be present, even in minute quantity, a well marked and absolutely characteristic ring of magenta appears within from one to three minutes at the junction of the fluids and gradually spreads upwards pervading the whole ammonia solution if acetone is present in considerable amount. In the absence of acetone usually no coloration appears, but sometimes an orange-red ring forms at the junction of the urine and ammonia solution, but this bears no resemblance to the acetone ring. It is important that the solution of nitroprusside of sodium be freshly prepared by dissolving a few crystals in a test-tube of water.

A Review of One Hundred and Five Reported Cases of Acute Pancreatitis, with Special Reference to Etiology.—Egdahl (Bulletin of the Johns Hopkins Hospital, April, 1907) present a literary resume of the subject, together with a report of two cases of his personal observation. He deducts the following inferences: 1. Gall-stones are probably the most common single cause of pancreatitis. Judging from this series about 42% of the cases of acute pancreatitis are associated with gall-stones. 2. Gastro-intestinal disorders are the next most common cause of acute pancreatitis. In this series of cases about 30%

belong to this group. Seventeen out of thirty-two of this group gave a history of alcoholism. It is very probable that the retrojection of bile may be caused by intestinal disorders closing the papilla of Vater. 3. Acute pancreatitis may be caused by many other conditions. Among them we have typhoid fever, tuberculosis, mumps, trauma, syphilis, emboli, appendicitis, malaria and gastric ulcer. 4. The organism most commonly present is bacillus coli communis; next comes the streptococcus and the staphylococci. 5. Typhoid fever is the most common of the acute febrile diseases present, according to the previous histories of these cases of acute pancreatitis. In the present series three were directly associated with typhoid fever alone, and four had suffered from typhoid fever some time before the onset of the acute pancreatitis, and had apparently recovered; another had had typhoid fever and erysipelas. But two out of these eight cases were associated with gall-stones. It should be kept in mind that in this latitude typhoid is the most common continued febrile disease.

Endocardial Friction Sounds. — Geigel (Muenchener Med. Wochenschrift, No. 15, 1907) calls attention to the fact of the possibility of an endocardial friction sound, which may not infrequently be heard in cases of acute endocarditis. The production of the murmur is analogous to both pleural and pericardial friction sounds; the inflammatory excrescences and roughened surfaces on the margins of the segments of the valves rub together during the act of closing thus causing a murmur.

Gastroscopy.— Jackson (Medical Record, April 6, 1907) reviews the literature on this subject, and relates his personal experience with a gastroscope of his own construction. His paper, which is fully illustrated, is concluded as follows: 1. History.—The attempts made in the past to examine the stomach gastroscopically were abandoned because no practical instrument was devised. 2. Usefulness.—Gastroscopy is not simply a fact. It has a field of usefulness that will increase as our skill and knowledge increases. Gastroscopy, in the author's opinion, is useful for the detection and removal of foreign bodies, the diagnosis of many pathological conditions, as inflammation, ulceration, scars, neoplasms, dilated vesels, and the treatment of at least one of these conditions, namely, benign ulcer. When the gastroscope shall have gained its deserved recognition, malignant disease of the stomach will be diagnosticated in many instances sufficiently early to give the abdominal surgeon a fair chance. Better still, a positive diagnosis of precancerous conditions will be made sufficiently early to enable him to save lives that are now being lost through reluctance of the patient to submit to an exploratory celiotomy. Gastroscopy is not offered as a substitute for an exploratory operation in every instance, but only in those cases in which the patient declines to submit, or in which the surgeon or the physician considers a simple procedure almost free from risk preferable to operative exploration. Gastroscopy is the only method known today that yields ocular information as to the condition of the gastric mucosa. Other methods give information only by inference from the disturbance of function. Thus gastroscopy becomes an auxiliary. 3. Results.—With the gastroscope the author has made a diagnosis of chronic gastritis in two cases; gastroptosis in two cases; malignant disease of the cardia in two cases; and of pylorus in three cases; in two of these cases a specimen was taken. A diagnosis of peptic ulcer was made in five cases, one of which was cured by direct applications. In one case negative results of value were obtained. The author has removed one foreign body from the stomach, being a forceps jaw lost therein by himself. In one case the gastroscopic findings enabled a diagnosis of gastric syphilis. 4. Limitations.—Negative results from gastroscopy are of limited value, because we cannot be certain that no lesion exists in the unexplorable area. But with greater perfection and skill this unexplorable area will be very much diminished. 5. Anesthesia by ether is preferable. Chloroform is unsafe alone, although it may be added as needed for relaxation. Cocaine, though an adequate analgesic, does not stop the retching which will interrupt so constantly. 6. The explorable area, with a stomach of the classic shape and position is the middle third. More than a third of the greater curvature is readily seen, likewise of the anterior and posterior walls at their inferior portions, the lateral extent of the field diminishing upward toward the esophageal orifice. The fundus and pyloric ends can be brought within range of the gastroscope by the external assistance of an expert abdominal manipulator, the tube being withdrawn within the esophagus until the new field is in place. In vertical and gastroptotic stomach, the lesser curvature and the pyloric third are readily explored with little or no external manipulation, and in some instances the pylorus can be seen. 7. Dangers.—In a patient with a normal esophagus and stomach, the only danger is that of ether anesthesia. An ulcer of the esophagus or stomach constitutes an exceedingly slight risk, unless the ulcer

bed be so thin that it would perforate within a few days by erosion, or by the normal spontaneous movements of the stomach. In chronic inflammatory states of the stomach no risks are incurred. In malignant disease a specimen may be taken with little risk in fungating conditions, but in flat ulcerations suspected of malignancy, the biting out of the edge of the ulcer, though very easy of accomplishment, is unjustifiable. The danger of hemorrhage in gastroscopy is nil in the normal stomach; in the diseased stomach it exists only in cases which are about to bleed, anyway, and none such were encountered in this series. There was no bleeding following the taking of a specimen in two, instances. The foregoing statement is based upon gentle manipulations, and the observance of certain rales, the most important of which is the immediate withdrawal of the gastroscope within the esophagus should retching supervene, waiting for the readvent of deep anesthesia before again pushing the tube downward. 8. Any physician can learn to examine the stomach with the gastroscope. 9. As to the future of gastroscopy: Will every physician have a gastroscope? No. No more than every physician has an ophthalmoscope.

Observation on the Diagnostic and Prognostic Value of the Eosinophiles in the Circulatory Blood.—Blumgart's (Medical Record, April 6, 1907) paper is intended to call attention to the diagnostic and prognostic worth of the eosinophiles in some parasitic and infectious diseases and to emphasize their prognostic value in typhoid fever. The writer details two cases of parasitic infection, one, a case of trichinosis closely simulating typhoid, the differential features being an eosinophilia of 39.8%, and the other, a case of rectal infection by schistosoma hematobium with an esinophilis of 25%. The following are the conclusions deducted by the author: 1. It is of importance not only to count the leucocytes, but to make a careful differential count and to repeat it frequently throughout the course of the disease, until in fact the patient is discharged. 2. The entire disappearance or very marked diminution of the eosinophilia, together with a distinct leukopenia, goes far to establish the diagnosis of typhoid fever in doubtful cases. 3. A normal or increased percentage of eosinophiles, other things being equal, speaks against typhoid. This holds good, of course, only for the febrile course of the disease. 4. In cases of undoubted typhoid, the presence of eosinophiles, even in small numbers, during the first week is a favorable sign, and speaks for a probable mild type. 5. No typhoid fever patient should be considered cured or dismissed from observation before he has regained permanently, at least, a normal percentage of eosinophiles.

THERAPEUTICS.

E. S. McKEE, M. D.

Treatment of Sciatica.—(The following is taken from the Monatsschrift fuer Orthopaedische Chirurgie und physikalische Heil und Untersuchungsmethodon, No, 4, April, 1907, beilage zu Deutsche Medizinal Zeitung 25 March 28, 1907 of Berlin under the title Behandlung der Ischias von Dr. E S. McKee, Cincinnati, and is abstracted from the original in Blatter fuer Klinische Hydrotherapie, Feb., 1907, of Vienna.)—First a calomel purge then salts; in constitutional disease as soon as possible introduce treatment for the cause; caution with morphium, in rheumatic cases salicylate preparations, in syphilis iodides, in gout colchicum and saline mineral waters. Hypodermic injection of sterilized air. First sterilize the media cutaneous region, then insert a sterilized Pava's needle into the skin and connect with a thin rubber tube, which is again connected with a glass tube containing a bit of sterilized cotton, and then one drives by means of a rubber balloon the air slowly under the skin. Naturally, care must be taken that the Pava's syringe needle be not run into a blood vessel, which easily occurs. Gentle massage should follow this procedure till the air is all absorbed. The rest cure of Weir Mitchell is in some cases very successful, especially in those where their means of livelihood has been an active one; massage along the nerve, though quite painful often breaks up adhesions which are the cause of the disease in many instances. It is a rule, however, that in true neuritis, massage is not followed by good results. Massage and especially mechanic vibrations are of especial worth in chronic cases with beginning atrophy. Hydrotherapy systematically used deserves due consideration. The wet pack over night diminishes the pain remarkably as well as having a favorable influence on the neurotic process. The next morning the leg is unpacked, washed with warm water and massaged. Ten or twelve of these applications are usually sufficient. In subacute cases the half steam bath is of service. Patient sits in a steam container which reaches above the hips. This half steam bath does not weaken the patient, and allows of a higher temperature, 44 deg. C., can be endured for ten to fifteen minutes without discomfort. Afterwards the patient

is put in a bath of 35 deg. C. for eight minutes and douches the diseased hips with water at 40 to 44 deg. C. This procedure can also be combined with swimming baths, and very often the drinking of large quantities of water is advisable. Electrotherapy, galvanic current direct on the nerves four to eight minutes, highest three to five milliamperes. Also the interrupted galvanic current stimulates the muscles in a mild way, holds the tissues in a good condition and prevents atrophy. The static (Franklin) douche with positive pole on the painful part is followed by good results. The apparent anodyne action of faradism in sciatica is due to its alterant action on the muscular tissue and through that on the circulation. The current dare not be increased to painfulness. Surgical Treatment.—In long standing cases one is often lead to make an exploratory incision, lay the nerve bare, and separate some adhesions. In bloody nerve stretching, we find good and bad experiences. This operation is directly contraindicated where neuritis is present, as in these cases myelitis not infrequently follows. There is also a so-called nerve stretching wherein the patient is under ether, the thing is forcibly flexed on the hip-joint with the leg extended at the knee, which position is maintained for some minutes. The cure is easier when the patient is not too old and does not suffer from other diseases. The principal thing in the treatment consists in the careful observation of the patient, so that nothing is overlooked. The physician shall at once in the beginning commence with a systematic cure, and if it does not go forward seek for his failure, for failure lays somewhere certainly. Exact diagnosis of the condition of the patient is the first and last means of treatment.

Iodine and Some of Its Uses in Surgical Work.—(John Egerton Cannaday, surgeon-in-charge Sheltering Arms Hospital, Hansford, W. Va., American Medicine)—Iodine is an exceedingly active substance chemically, and belongs to the halogen group. It possesses great affinities for many substances, and its exact use and sphere of action in the body are unknown. It enters largely into the composition of sea food and animals subsisting on this food contain their share of this evanescent substance. It makes the circuit of the body circulation in a short time and is eliminated in the saliva, urine and feces. Senn, in his recent trip among the Esquimaux noted that iodine is liberally incorporated in the food of these people. He observed the remarkable absence of tumors of all sorts, the exceedingly benign course of syphilis, the absence of enlarged tonsils, lymphatic glands and goiter. He attributes this immunity to their use of iodized food. Sternberg, Senn, Koch, Schill, Fisher, Behring, Tavel, and more recently Kinnaman, have emphasized the value of iodine as an antiseptic. It is certainly the most powerful as well as the least harmful germicide we possess.

Kinnaman has performed an unusually elaborate and careful series of experiments with a view to the determination of the actual antiseptic value of the drug. He made use of a solution containing iodine 2.5 gm., sodium iodid 5.5 gm., sterile water 250 cc., making 1-100 solution. A 1-100 solution or mercuric chlorid acting on a culture of streptococcus pyogenes for fifteen minutes showed a good deal of inhibitory power for the first day, but allowed a good growth of streptococci to appear. An exposure of thirty minutes, however, gave no growth. The superiority of iodine is readily evidenced by the fact that a comparative weak solution (0.2 per cent) killed the streptococcus after two minutes exposure. To iodine the staphylococcus is far more resistant than is the streptococcus. While it takes a 1-100 solution five minutes to kill the former, a 1-500 solution in fatal to the latter in two minutes. Dr. Kinnaman's conclusions are that in a solution of iodine varying from 0.2 to 1-6 per cent, we have a germicidal agent of marked potency. Its bactericidal power is far superior to mercuric chlorid, the acknowledged leader of all antiseptics.

The author reports a case of multiple tuberculous abscesses of the muscles of the chest and back treated by repeated injections of iodoform in olive oil in which the results were most gratifying. He calls attention to the fact that the injection of the emulsion into the joint is naturally followed by a rise of temperature which may last for several days.

The iodoform gauze treatment of puerperal sepsis introduced by the late Dr. Pryor, of New York, is commented on most favorably. The method is considered to be unassailable from a deductive as well as a resultant point of view. Pryor packed the uterus and the retro-uterine space with iodoform gauze after thorough curetting and irrigation. The iodoform gauze filling of von Mosetig-Moorhoff has been found to be a most valuable adjunct in the treatment of the circumscribed chronic osteomyelitis.

Aumond and Bonnaire use the following formula for an irrigating solution: iodine 3 gm.; potassium iodid 6 gm., water 1,000 gm. They make use of the pure tincture as a local application prior to curettement as a means of partially sterilizing the inside of

the uterus. Many of the old-time gynecologists were in the habit of making an application of the plain tincture to the inside of the uterus after curettement.

Iodine in weak solution as an irrigation is of much value in the treatment of suppurative conditions, as suppurative arthritis, abscess, empyema, etc. The author has several times used a one per cent solution in the treatment of suppurating sinuses and wounds with the result that there was a prompt disppearance of pus and an abundant formation of healthy granulation tissue.

It must not be forgotten that, although iodine is the most harmless of antiseptics, it and its compound iodoform are active agents, and as such should be used with caution. They are under circumstances powerfully toxic. It is after injection into serous cavities that the most serious results are seen. The pyogenic membrane lining the tuberculous or pus cavity seems to possess the power of immunity to a marked degree. The old and enfeebled patient will be much more susceptible to the poisonous action than the more robust. It is a well known fact that an individual suffering from septic infection will tolerate much more iodine without the symptoms of poisoning than one under normal conditions. Rarely there are found persons having so marked an idiosyncrasy for iodoform that it will act as a poison when exhibited in the usual manner in small amounts.

The writer uses a one-half of one per cent alcoholic solution for purposes of hand disinfection preliminary to operative work in all cases in which rubber gloves are not worn. The same solution is made use of in the preparation of the site of the operative incision. Rubber gloves are worn as a routine measure in operative work, but in certain number of these cases gloves are undesirable; again, in an occasional septic case, a glove may be punctured or torn, and the operator feels the need of some reliable antiseptic for his own sake as well as for the protection of his future patients. The use of this solution simplifies the technic and saves time. The method practiced is as follows: First thorough scrubbing with nail brush, green soap and running hot water, going over the hands in a systematic and methodical manner, taking each part in its turn and always following the same order as to skip no part. Particular attention is paid to the nail folds subungual spaces, and the skin between the fingers. Short clipped nails should be cleaned with an orangewood stick, the hands scrubbed again, washing off the soap in running hot water. Remove the residue of the soap with 70 per cent solution of alcohol, immerse in iodine solution for five minutes, rinse in sterile water. The light-brown stain can be removed by washing in dilute ammonia water after operations, or if left alone will soon disappear.

The results clinically of this method have been superb. In a long series of cases no infection attributable to the hands has occurred.

In conclusion, the author states his belief that iodine constitutes a near approach to a perfect antiseptic in that it is non-toxic in effective strength, being one-fourth as poisonous as mercuric chlorid though many times more valuable as a germicide. It does not coagulate albumin or form inert compounds with the tissues. It possesses great penetrating power, is easily prepared and is stable. A solution of iodine is the most practicable chemical agent we have for the sterilization of the skin.

America leads in the matter of women practising medicine. The first was Elizabeth Blackwell, who graduated as physician in 1849. Three years later, there were six in Philadelphia. In 1889 there were 3,000 women doctors in the United States; in 1896 there were 4,555, and now there are probably 6,000.

The Opsonic Index.— The profession has desired a practical exposition of the theory of the opsonins and the application of the same in practice, two excellent papers have recently been published in the Therapeutic Gazette which give the details desired and that in a concise and comprehensive manner. These papers, "A Review of the Opsonins and Bacterial Vaccines" by E. M. Houghton, Ph.C., M.D., and "Directions for Determining the Opsonic Index of the Blood" by E. C. L. Miller, M.D., have been published in reprint form by Parke, Davis & Co., Detroit, and a copy will be sent to physicians who signify their desire to receive it.

American Anti-Tuberculosis League.— The American Anti-Tuberculosis League, organized to prevent consumption, to educate the people, to secure state aid and to establish hospitals, etc., will hold its next meeting June 1 to 4, 1907, at Atlantic City, N. J. Special subjects for discussion will be "Tuberculosis and Milk" and "Tuberculosus in in the Negro Race." Hon. Nathan Strauss New York who has done so much for the bettering of milk supply will preside at the meeting which takes up the subject of milk. Further information may be obtained from Dr. George Brown, Atlanta, Ga., president and executive officer.

THE MEDICAL FORTNIGHTLY

A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scientific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

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THE SPIRIT OF THE MEDICAL PRESS.

The Medical Inspection of School Children.—Of the utmost importance, not only to the present condition of our public health, but also to the future welfare of our citizens, is the question of medical inspection of school children, which is at present exciting a good deal of comment. The future of our country and race lies more in the efficency of the public school than in any other single factor. A systematic scheme of medical inspection has not yet been put into practice in this country, and is only in its youth in England. Germany, however, has long recognized the value of such inspection, and has employed a corps of medical men to examine school children for some years. President Eliot, of Harvard University, is responsible for the statement that, in the primary grade of school life in this country, forty per cent of the children are beyond the normal age for the grade in which they are working, and twenty to forty per cent in grammar schools are over the maximum age for that grade. We need hardly state that mental progress is retarded, and mental dullness of marked degree often induced by errors of vision, deficiency of hearing and the presence of adenoids. In the superficial examinations made so far in this country, some remarkable statistics have been compiled. In Philadelphia, sixty-four per cent of incorrigible children presented marked physical defects. In New York, where seventy-five thousand school children were examined during the last year, twenty-four thousand showed defective vision, sixteen hundred defective hearing, and fifty thousand nine hundred, had these and other defects that required medical attention. Lovett states, "it is of little use to know that twenty-six per cent of school children have lateral curvature of the spine, and that it progresses during school life from about eighteen per cent in the lower grades to thirty-three per cent in the higher grades, unless we do something about it in the way of providing proper school furniture."—Interstate Med. Jour.

The Opsonin Theory.—The universal interest manifested by the medical world in the subject of immunity leads us to review in a brief manner the two great theories which are accepted by the scientific world as explanations of the facts in immunity—those of Metchknikoff and Ehrlich. The cellular theory of Metchnikoff taught that all bacteria invading the body were destroyed in the leucocyte and that these cells through their ameboid movement were able to protect the body from disease. In his earlier studies Metchnikoff made no attempt to analyze the machinery concerned in the production of immunity or to explain its long duration in many diseases. Ehrlich, on the other hand, ascribed immunity to the combined action of multitudes of body cells whose defenses against disease were graphically pictured as projections of cell protoplasm, or side chains, cast off into the body fluids, becoming attached to the toxin molecules so that the toxins were prevented from poisoning the body cells. He further described substances in the body fluids, especially the blood serum, which were necessary for the union of the side chains with the toxin. These substances (complements) are present in all sera and there are probably many differnt varieties. Complements are readily destroyed by heat, light or exposure to air. Since the publication of Ehrlich's theory of immunity the blood serum has been a most fruitful field for research. Other substances called agglutinins are formed in the serum of animals suffer-

ing from certain kinds of infections which produce clumping of a culture if placed with a portion of diluted serum. Precipitins are substances closely related to agglutinins, and produce a precipitation of the bacteria in large masses if mixed with diluted portions of their specific immune serum. Another substance, bacteriolysin, is described by Ehrlich as causing destruction of the bacterial cell. Agglutinins, precipitins and lysins, although closely related to each other are generally conceded to be distinct substances. They are all more stable than complement in their resistence to heat, light, drying and other destructive agencies. The work of Sir Almroth E. Wright of London and his associates in the last three years has revived the theory of phagocytosis and a vast amount of research has been accomplished in the study of the polynuclear leucocyte and its phagocytic action. These workers describe still another element in the blood serum, distinct from complement—agglutinin, precipitin and lysin—which they have called opsonin. This substance prepares the bacterium so that it is more readily destroyed by the phagocyte. The opsonic index has been most thoroughly studied by Wright and his associates in localized tuberculous lesions and various septic infections. Individuals suffering from a tubercular infection usually have an opsonic index for tubercle bacilli below normal, but after an inoculation of a suitable dose of tuberculin the tuberculo-opsonic index increases in the serum and the leucocytes are able to destroy many more bacilli than before the injection of tuberculin, and the continued treatment with suitable doses of tuberculin has resulted in a complete healing of the lesion. Most of the work reported by Wright with culture products of the tubercle bacillus has been in local tubercular lesions, and careful tests in determining the opsonic index have been followed as a guide to the treatment. Similar treatment has been carried on by these and other workers in acne, furunculosis and allied septic conditions. The technique, while comparatively simple may seem somewhat complex to those not intimately in touch with laboratory work. A suspension of the bacterium to be used is reared in physiological salt solution and is mixed with equal part of washed blood corpuscles and blood serum. These three substances are mixed in a sealed glass tube and incubated for a certain length of time so that the phagocytes may have opportunity to act on the opsonized bacteria. A smear of this mixture is then prepared and stained and all bacteria found in a given number of leucocytes are counted and an average obtained of the number in each leucocyte This constitutes the opsonic index and the work is controlled by tests with normal serum. If the patient whose opsonic index is tested for a specific bacterium should receive a suitable dose of vaccine of this specific bacterium and his opsonic index determined again in the manner described above, it will be found that the leucocytes have been able to destroy many more bacteria than before the vaccine was administered. The practical application of this work to diagnosis and treatment in medicine and surgery is a phase of the subject widely discussed. The specificity of opsonins for the particular organism for which they are formed seems to be fairly well established, and if a marked increase in the opsonins for a specific bacterium is observed, and such work is verified and controlled and repeated, a diagnosis not only can be made, but the patient may be treated by suitable doses of the specific vaccine so that operative measures may not be necessary. The next few years will probably determine in a large measure just how much value may be attributed to specific opsonins in medicine and surgery. In the treatment of septic conditions the vaccine should be prepared if possible from the lesions produced in the patient, far better results are uniformly obtained from such vaccines. The difficulties in the application of the opsonic index to clinical medicine have been overcome in a measure by individual workers in different parts of the country, but the technique is difficult, uniform results are not obtained and the work is not satisfactory in the hands of those who have not been thoroughly trained in elementary bacteriological technique.—So. Calif. Pract.

ACNE.—

℞ Resorcin ..... iiss
Zinc oxid 3vj
Starch 3vj
Lanolin (Liebreich) q.s.ad 3iij

FACIAL ECZEMA.—

Ac. camphoric ..... gr. xv
Bismuth subnit ..... gr. xxx
Zinc carb. precip. ..... gr. xxx
Starch ..... gr. xxx
Vaseline 3 1¼
Lanolin (Leibreich) 3 1¼

RECTAL FEEDING.—Boyd and Robertson (Scottish Medical and Surgical Journal) recommend the following nutritive enema:

℞ Yolks of two eggs.
Pure dextrose ..... 30.0 grammes
Sea salt ..... 5.0 grammes
Pancreatized milk .. 300.0 c. c.

M. S.: Inject into the colon four such injections daily, through a soft tube.

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ABSOLUTELY HARMLESS.

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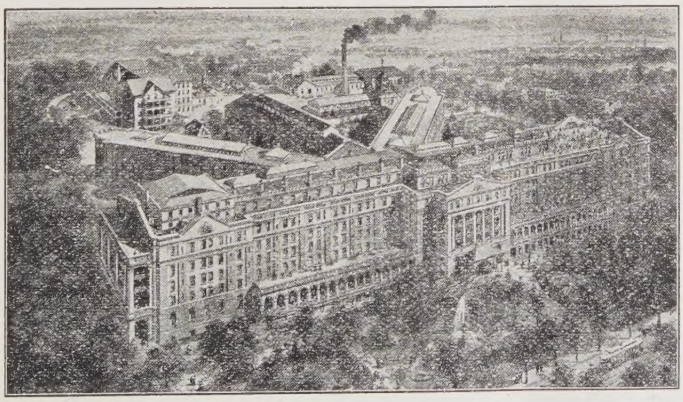
Rest, Recuperation and Health at the Battle Creek Sanitarium



An examination of their illustrated booklet shows how different the Battle Creek Sanitarium is from other health resorts. Its cuisine, conducted according to the Calorie system is different. Its remarkable system of baths, including Nauheim is different. Its system of manual Swedish movements is different. Its school of health is unique and fascinating. Its care and treatment of guests, especially invalids, are peculiarly its own. Indeed, the whole vast institution, its atmosphere and environments are suffused with what has become known the world over as "The Battle Creek Idea."

Its main building, absolutely fire-proof, contains seven acres of ideal indoors. It has over 100 suites with private baths, telephone in every room, model kitchen and sunny dining rooms on top floor with 50-mile view, great palm garden, delightful sun parlors, elegant lobbies, parlors and rest foyers, wide porches and spacious home-like rooms. It employs the most elaborate and costly scientific equipment for phototherapy, electricity, X-ray electric light baths, Finsen rays, etc.

The rates are moderate. Board and room, including baths, services of bath attendants and necessary medical attention, cost less at the Battle Creek Sanitarium than board and room alone at many resort hotels not so elegantly appointed.

Those desiring absolute quiet and rest can have it at any time. For those desiring them, there are marches, lectures, stereopticons, musicales, contests, exhibitions, walking, driving, tally-ho and picnic parties and other indoor and outdoor entertainments and amusements. Write for a copy of their catalogue.

Address Box 204, The Sanitarium, Battle Creek, Mich.

All through railroad tickets have stop-over privilege at Battle Creek.

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For Sale.—First-class vibrator (electric) and static machine, little used. A great bargain. Address, "Retired" care Medical Fortnightly, St. Louis, Mo.

Administered After Operation, Fellow's hypophosphites exercises a most beneficial influence upon the patient's nutrition, fortifying the recuperative powers, and thereby hastening convalescence.

I do not hesitate to declare myself a friend of resinol ointment and soap. I have used them with splendid results in herpes, eczema psoriasis and pruritus. I shall continue to recommend and describe them.—Dr. Jose R. Pimental, Acambaro, Gto., Mexico.

Far Superior to Chloroform.—The hyoscine-morphine-cactin anesthetic (Abbott) has been entirely satisfactory. In obstetrics it is far superior to chloroform. No nausea, shock or disagreeable symptoms with the mother. The child is born cyanotic, but comes round all right. Our county medical society has taken up the matter; all reports have been very favorable. I think it will have a national bearing in the increase of population, as women will cease to dread the pangs of child bearing, and will increase the number of children born. The nation will owe you a debt of gratitude.—J. S. Dickenson, Trenton, Ky.

Clinton Cascara Active, as prepared by Bristol-Myers Co., Brooklyn, New York, is a true representative of all the valuable constituents of cascara bark, free from bitterness and rendered exceedingly palatable by special treatment and combination. The name "Clinton Cascara Active" has been applied to this preparation to distinguish it from aromatic fluids, elixirs and cordials of cascara, which are comparatively feeble preparations, requiring large doses to produce any characteristic effect. On the othe hand, Clinton cascara active is of the same strength as a fluidextract, one fluidounce imperial representing one avoirdupois ounce of carefully selected drug. This preparation is a most useful remedy both regarding its immediate effects and its after-results in obstinate and chronic cases of constipation.

Light Therapy.—The recent development of various forms of apparatus for the application of light as a therapeutic agent emphasizes the worth of this agent. It has been found especially effective in skin diseases, in fact the leading dermatologists testify that there are few diseases of this class which are not definitely improved by light intelligently applied. The successful application of light is dependent primarily on a well constructed lamp, failure usually means poor apparatus. A dependable lamp such as manufactured by Huston Brothers Co, will give uniformly excellent results. The explanation of the therapeutic effect of light in dermatology is explained in the fact that the blood absorbs light in a high degree ; the best authorities tell us that there is especially one constituent of the blood that uniformly absorbs light, namely, hemoglobin. We also know that light irritates the cutaneous nerves, and thus affects the entire central nervous system. It increases the oxidizing processes in the cells and the amount of hemoglobin in the blood. The capillary dilatation is an invariable effect, and it has also great anesthetizing powers. The action of the ray is so sure that it has been used frequently as a test of correct diagnosis. It is not our purpose to go into extended defense of this comparatively new treatment, nor indeed is such a defense necessary. All physicians of course should keep up with the latest scientific progress, and it would be a truism to refer to electric light therapy as scientific Wc recommend our readers to write for much valuable information along this line to Huston Brothers Co. of Chicago, whose adv. appears in this issue.

The Treatment of Inoperable Tumors (Carcinoma) is the subject of an article by Prof. J. M. G. Carter, which he read before the Illinois State Society and printed in a recent number of the Illinois State Medical Journal. He says, in part, since nuclein contains phosphorus, it is a tonic and besides its germicidal properties, it has other therapeutic value. That it is a rational agent in the treatment of various dyscrasiae is attested by clinical experience. For a number of years the writer has used nuclein with such success as to lead him to hold it in high regard as an agent for the treatment of malignant growths and other low dyscrasiae. The particular preparation was Reed & Carnrick's prótonuclein. The bromid of gold and arsenic is another remedy, which, in my hands, has seemed to prove useful in the treatment of inoperable carcinoma, but I have always used it in connection with other agents. I have had more confidence in the nuclein than in the bromid chiefly perhaps because I had two cures in which I did not use the bromid, while I have had none where nuclein was not use. I have come to consider the administration of nuclein and the bromid of arsenic and gold together as a most rational and valuable treatment in cases of inoperable carcinoma. It is the combination upon which I depend rather than on either agent singly. I have use this method of treatment in many cases with apparent benefit, but I am able to report only five cases in which the treatment was carried out as prescribed from the time the patient came under my observation until the termination of the case. One of the cases died. The other four recovered.